# PATIENT REGISTRATION

Title: Mr./Mrs./Ms./Dr./Rev./Rank_____ Date: _____

Last Name_____ First Name_____ M.I_____ Nickname_____

Address_____ City_____ State_____ Zip_____

Mobile Phone_____ Home Phone_____ Work Phone_____

E-Mail_____ SSN _____

Date of Birth_____ Age_____ Gender: M F Marital Status: S M W D

Employer Name_____ Occupation_____

Spouse Name_____ Phone_____ Employer/Occupation_____

Children (names, ages) _____

## INJURY INFORMATION

Date of injury: _____

Please write a brief description of how your injury occurred:

_____

_____

_____

*If you injury is NOT due to an automobile collision, please skip to the section titled "Areas of Complaint"*

UPON IMPACT (Please CIRCLE the option that applies) :

Were you stopped? Yes / No If no, approximate speed: _____ mph

Was the other vehicle stopped? Yes / No If no, approximate speed: _____mph

Was your body straight in your seat? Yes / No if no, turned to the Left / Right

Were you looking straight ahead? Yes / No if no, was your head turned to the Left / Right / Up / Down

Were you aware that you were about to be hit? Yes / No

Were you wearing a seatbelt at the time of the accident? Yes / No

Did your chest / head hit the steering wheel? Yes / No Did an airbag deploy? Yes / No

Did your head hit the Windshield / Side Window? Yes / No Did your shoulder hit the door? Yes / No

Did your knees hit the dashboard? Yes / No Did the seat break? Yes / No

Do you have any cuts / bruises from the accident? Yes / No If yes, where? _____

Was your car equipped with headrests? Yes / No

If yes, at what height was the top of the headrest? Base of head / Mid head / Top of head

Did you lose consciousness? Yes / No If yes, how long _____

NAME:

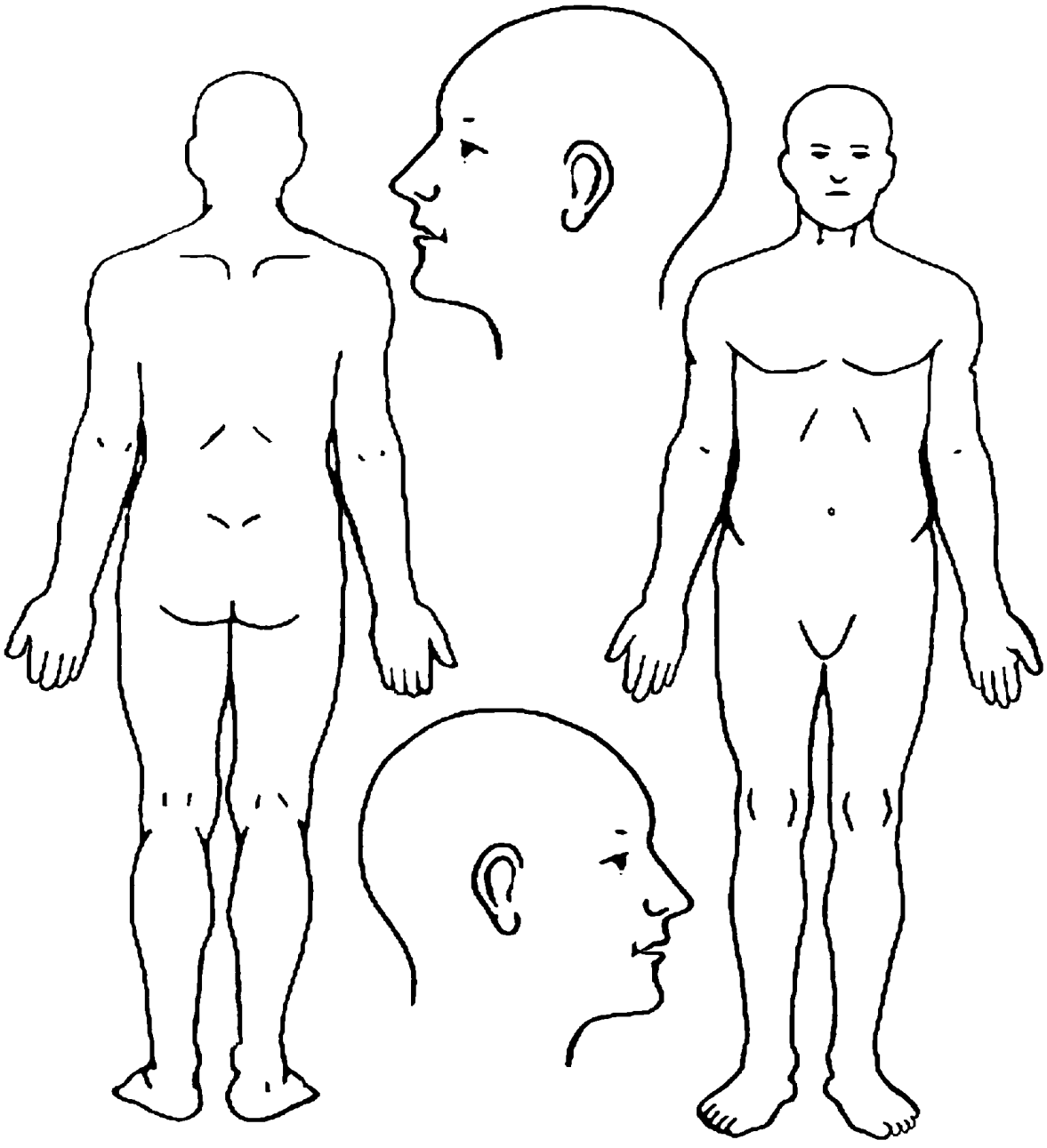
_____DATE_____

# BORG PAIN SCALE

## On a scale of 1-10, please rate your pain level.

| Normal | Low Pain | Moderate Pain | Intense Pain | Emergency |
|---|---|---|---|---|
| ( ) 0 | ( ) 1 | ( ) 4 | ( ) 7 | ( ) 10 |
| | ( ) 2 | ( ) 5 | ( ) 8 | |
| | ( ) 3 | ( ) 6 | ( ) 9 | |

## Please place "X's" where you feel your pain.



Are you experiencing any of the following since your injury? (mark all that apply)

___Dizziness/Loss of balance
___Anxiety
___Memory lapses
___Headaches
___Blurry vision
___Neck Pain
___Numbness/Tingling to Arm/Hand
___Fatigue
___Sore throat
___Shoulder Pain
___Elbow Pain
___Wrist/Hand Pain
___Upper Back Pain
___Mid Back Pain
___Chest Pain
___Breathing Problems
___Digestive Problems
___Urinary difficulties
___Low Back Pain
___Numbness/Tingling to Leg/Foot
___Hip Pain
___Knee Pain
___Ankle/Foot Pain

Did you have any of the above complaints before your injury? Yes / No

## TREATMENT INFORMATION

List all the doctors that you have seen as a result of your injuries:

| | Date | Doctor/Hospital | Treatment |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Do you have any future appointments with any doctor regarding your injuries? Yes / No

## HEALTH HISTORY

Current medications

1. _____
2. _____
3. _____

Please list all past surgeries, major illnesses or diseases, hospitalizations (with approximate date)

1. _____
2. _____
3. _____

Please list any previous accidents and injuries:

1. _____
2. _____
3. _____

Family History

| | | | | | | |
|---|---|---|---|---|---|---|
| Mother's Side: | Heart Disease | Stroke | Arthritis | Cancer | Diabetes | Other_____ |
| Father's Side: | Heart Disease | Stroke | Arthritis | Cancer | Diabetes | Other_____ |

Females: Are you pregnant? Yes / No If so how many weeks? _____

**********

I attest that all of the above information is correct to the best of my knowledge.

Patient/Guardian Signature_____ Date _____

# Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

**1. Pain Intensity**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

**2. Sleeping**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

**3. Personal Care (washing, dressing, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

**4. Travel (driving, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips |

**5. Work**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

**6. Recreation**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

**7. Frequency of pain**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

**8. Lifting**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

**9. Walking**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; any distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking |

**10. Standing**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing |

**Name** _____
**PRINTED**

_____
**Signature**

_____
**Date**

**Total Score** _____

# ASSIGNMENT OF BENEFITS

PATIENT: _____

INSURANCE COMPANY: _____

DATE OF LOSS: _____ POLICY #: _____ CLAIM #: _____

The undersigned patient and/or responsible part, in addition to the continuing personal responsibility and consideration of treatment rendered or to be rendered, assigns to Corrective Chiropractic PA (CCW) all benefits payable under the terms of my/our policy benefits.

Release of Information: CCW is authorized to release information concerning my condition and/or treatment to my insurance company, attorney, or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me.

Irrevocable Assignment of Rights: CCW is assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable rights to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, and other legally compensable amounts owned by and insurance or stat statue. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

Demand for Payment: To any insurance company providing benefits of any kind to me/us for treatment rendered by Corrective Chiropractic PA, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill services to extent such bills are payable under the terms of my/our policy for benefits, ales any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, collecting percentage penalties, court costs, and interest from judgment, upon violation.

Third Party Liability: If my injuries are the result of negligence from a third party, then instruct the liability rendered, payable directly to Corrective Chiropractic PA. If the liability carrier will not cut a separate check to Corrective Chiropractic PA, I am giving the liability carrier permission to enter Corrective Chiropractic PA's name on the draft that I am to receive for my medical expenses.

Statute of Limitations: I waive my rights to claim any statute of limitations regarding claims for services rendered, or to be rendered, by Corrective Chiropractic PA. In addition to reasonable costs of collection including attorney fees and court costs, if incurred.

Limited Power of Attorney: I hereby grant Corrective Chiropractic PA the power to endorse my name upon any checks, drafts, or other negotiable instrument from any insurance company representing payment for services rendered by Corrective Chiropractic PA. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account.

Termination of Care Waiver: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, or if I/we choose to see another doctor, I will notify Corrective Chiropractic PA immediately.

*A photocopy of this instrument shall serve as an original.*

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

# AUTHORIZATION AND ASSIGNMENT

Corrective Chiropractic, in consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release my information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred.
- I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
- In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Texas.
- I further agree that this Authorization and Assignment is irrevocable until all monies owed Corrective Chiropractic, are paid in full.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

# ADDITIONAL PRIVACY PRACTICES

- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

# ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) healthcare services at Corrective Chiropractic PA and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- That there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to Corrective Chiropractic PA, or make other provisions for the protection of the interest of Corrective Chiropractic PA or
- If a liability claim exists, and my attorney refuses to agree to protect the interest of Corrective Chiropractic PA, or if I have not engaged the services of an attorney; then payment for services rendered by Corrective Chiropractic PA will be made on a current basis and my bill paid in full as soon as my liability claim is settled, or the passage of three months from my last treatment, whichever occurs first.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

# TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective: to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- Health/Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
    - In-Network Policies: We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement. Co-pays will be paid by patient, reimbursement checks will be payable to us.
    - Out-of-Network Policies: We will give you receipts to file with your insurance company. Patient will pay cash prices up front. Insurance company will reimburse the patient.
    - If your policy has a deductible feature, it is due at the time of service.
    - In accordance with Medicare Guidelines, Maintenance Care is not a covered benefit and therefore will not be billed to your insurance company.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

# INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURING

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED

- *Over-the-counter analgesics*. Temporarily relieves pain but does not address the cause of the symptoms. Masking the pain means you may not feel additional damage. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, injections, and analgesics. Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period _____ Initials_____

# Corrective Chiropractic and Wellness

## Acknowledgement of Receipt of Notice of Privacy Practices

***This form will be retained in your medical record.***

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**NOTICE TO PATIENT**

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:**_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Corrective Chiropractic and Wellness.

I understand that the Notice describes the uses and disclosures of my protected health information by Corrective Chiropractic and Wellness and informs me of my rights with respect to my protected health information.

_____ _____

*Patient's Signature or that of Legal Representative* *Printed Name of Patient or that of Legal Representative*

_____ _____

*Today's Date* *If Legal Representative, Indicate Relationship*

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**FOR OFFICE USE ONLY**

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We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

*Employee Name* *Today's Date*